Authorization to Use and Disclose Protected Health Information (PHI)

County of Orange, California

Health Care Agency

INSTRUCTIONS

Numbered items in these instructions refer to numbered items on the form.

"Note to Client: A fee may apply to this request": A fee for copies of medical records may be charged. This fee, which is set by the County of Orange, is $.10 per page/$4.00 for each 15 minutes of clerical time. You will be notified of the cost for your copies and this fee must be paid before the records are disclosed. There are exceptions to this cost including records disclosed to hospitals, providers and other government agencies. Also, for copies provided to the patient/client, there will be no clerical fee.

"Photocopy/Facsimile copy is as good as the original": This statement is made to ensure that the patient/client knows that this request form may be photocopied and/or it may be sent via facsimile. The client/patient gives permission for the form to be sent by facsimile because accessibility of the information to recipients who are not the authorized users of the information may occur when the form is sent by facsimile.

"Client/Patient Information" to be completed by requestor.

1 **Name** Indicate the name of the client/patient whose records and/or information is being requested for disclosure

2 **AKA** Indicate any other name by which the client/patient is known.

3 **SSN** Indicate the Social Security Number of the client/patient.

4 **Date of Birth** Indicate the date of birth of the client/patient.

"I, the undersigned, hereby authorize the 5 ☐ **USE** 6 ☐ **DISCLOSURE;** 7 ☐ **EXCHANGE;** 8 ☐ **REQUEST of the following records/information:"** To be completed by requestor. Requestor marks the box(es) which will apply to this request. More than one box may be marked if applicable.

5 ☐ **Use** Use means the sharing, employment, application, utilization, examination or analysis of the protected health information for the individual within the Health Care Agency.

6 ☐ **Disclosure** Disclosure means the release, transfer, provision of access to, or divulging in any manner of the protected health information of the individual outside of the Health Care Agency. Disclosure means to a party. For example, you would like the Health Care Agency to disclose your records/information to your private doctor, an attorney, the court, etc.

7 ☐ **Exchange** Exchange records means between parties. For example, you would like the Health Care Agency and the Probation Department to share records/information they have about you.

8 ☐ **Request** Request records means from a party. For example, you would like the County of Orange Health Care Agency to request your records/information from another provider, another County, etc.

9 ☐ **Records/Information From** Indicate name and address of the party who is disclosing the records/information. For example, if you would like the Health Care Agency to disclose your records, you would indicate the name and address of the Health Care Agency.

Sample:

9 **Records/Information From:**

County of Orange Health Care Agency

9A Name of Facility Producing Records

P.O. Box 355

9B Street Address

Santa Ana, CA 92702

9C City, State, Zip

10 Disclose Records/ Information To: This is the party to whom the records will be sent. For example, if you would like records/information to be sent to a doctor outside of the Health Care Agency, you would indicate their name and address here.

Sample:

10 **Send Records/Information To:**

Dr. Smith

10A Name of Facility Producing Records

12345 Main Street

10B Street Address

Los Angeles, CA 96394

10C City, State, Zip

***NOTE**: Because of confidentiality regulations, a separate Authorization to Use and Disclose Protected Health Information form must be completed and signed for <u>every</u> disclosure of information requested. For example, if you want your records/information from the Health Care Agency disclosed to Probation Department and to the court, you must fill out <u>two</u> Authorization to Disclose Protected Health Information forms.*

<u>DISCLAIMER FOR REDISCLOSURE</u>*:*

PHI pertaining to the treatment of psychiatric/mental health/psychotherapy notes; alcohol/substance abuse; HIV/AIDS; sexually transmitted disease (STD) treatment records are covered under the specific confidentiality codes listed for each category below. A general authorization for the release of medical or other information is not sufficient for this purpose. Redisclosure of each of these types of records is prohibited without the specific written authorization of the person to whom the treatment pertains or as otherwise permitted by these regulations or by federal law. The potential for information disclosed pursuant to this authorization is to be subject to disclosure by the recipient and is no longer protected by the County of Orange, Health Care Agency.

"Records/Info to be Disclosed: (Initial for each type of Record to be Disclosed. Please check all that apply): The requestor must place their initials in the box for each specific type of record/information that is being requested from the party in Section 9 of the form. Initials are **<u>REQUIRED</u>** for each separate type of record/information because of the different confidentiality guidelines that apply to each type of record/information.

Sample:

RECORDS/INFO TO BE DISCLOSED: (Initial For Each Type Of Record To Be Disclosed. Please check all that apply)

11 MEDICAL TREATMENT RECORDS/INFORMATION (California Civil Code 56.10, Title 17, Health and Safety Code 120175) AND OTHER INFORMATION

11A Initials	11B Treatment Date(s):	11C Facility Location(s)	11D Type of Record(s)/Information to be Released
JD	5/15/98 5/15/98	TB Clinic – 17th Street Immunization Clinic	☒ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below) _____

11 Medical Treatment Records/Information (California Civil Code 56.10, Title 17, Health and Safety Code 120175) and Other Information: Use this section if you are requesting medical treatment records/information, including general health information such as immunizations, TB clinic records, Maternal Health, STD information, California Children's Services records/information, etc. This sections also refers to any other types of records/information such as attendance dates for educational activities, prevention seminars, parenting classes, etc.

11A Initials: If medical treatment record Information is to be disclosed, place your initials in this section.

11BTreatment Date(s): Indicate dates of treatment for the records/information you are requesting. If you are unsure of the dates, write "any and all" in this area.

11C Facility Location(s): Indicate the location of the facility where you received medical or other treatment. Indicate the correct address of the facility location, for instance, if you received treatment at an HCA clinic in Santa Ana, you must specify which one.

11DType of Record(s)/ Information to be released: Indicate what type of medical records you are authorizing to be disclosed. You may select "any and all", please note that this will include any and all records that the facility has about you. You may select specific record(s)/info and then indicate what specifically you want to have disclosed.

You MUST indicate *how much* and *what type* of protected health information you want the Health Care Agency to disclose in order for this Authorization to be valid.

For Sections 12, 13, 14

Please follow the same guidelines for completing these sections as indicated in Section 11.

Section 12 – refers to Psychiatric/Mental Health/Psychotherapy notes covered under California W&I Code 5328.

If psychotherapy notes are being requested, a separate authorization form must be completed requesting that psychotherapy notes be disclosed. The Authorization to Use and Disclose psychotherapy notes CANNOT be combined with the Authorization to Use and Disclose other types of protected health information.

Note: This section shows reference to the California Health and Safety Code 123115 & 123130. This law allows the mental health provider to approve or deny personal access by you to your mental health information under certain circumstances. If you have questions about this, please speak to the Custodian of Records staff or to your mental health provider.

Section 13 – refers to Alcohol/Substance Abuse records covered under Section 42, Part 2 Code of Federal Regulations.

Section 14 – refers to HIV results/AIDS treatment records covered under Health and Safety Code 120980.

15 Purpose of the Disclosure of Information: Indicate the reason that the information is being requested. For example, if you are requesting that your medical records be sent from the HCA Santa Ana Clinic to a new doctor outside of the Health Care Agency so he can continue your treatment, you would write "Continuity of Care" in this section. You may also simply say" At the request of the individual."

16 This Authorization Shall Become Valid Immediately And Shall Remain In Effect For The Following Period: You may revoke this authorization to disclose PHI in writing at any time. Contact the Custodian of Records office to obtain the form. You **must** initial one of three choices for this request to be valid.

16A This authorization expires once information is disclosed. This is a one-time disclosure: Initial this section if you want specific information disclosed one time only.

16B This authorization expires six months from the signature date below: Initial this section if you want this authorization to expire six months from the date you have signed this form on Line 17.

16C This authorization expires as specified: _____ Initial this section and fill in a date if you want this authorization to be valid only until the date you have specified. For example, you can indicate an exact date, or you can indicate "Until the court case is closed", or "Until treatment is complete", etc.

17 Today's Date: This **must** be completed in order for the request to be valid. This date starts the clock for this authorization to become active. If no date is indicated, the request is not valid.

18 Signature: Requestor must sign the form to make authorization legal.

Note: The signature will be compared to the information in the medical record, or you may be asked to provide identification. The person completing this form must be the person who signs this form.

19 Printed Name: Clearly print the name of person signing the authorization.

20 Relationship: Please mark the box to indicate the relationship of the person signing the form. If you are the patient, mark client (patient), if you are the parent of the patient mark parent, etc. If none of the provided boxes apply to you, please mark other and fill in your relationship to the patient. Note: Supplemental documents that prove your relationship to the client/patient must be provided.

21 Complete Address: Please fill in the complete address of the person who is signing the form.

22 Telephone #: Please fill in telephone number of the person who is signing the form.

23 Please return the completed form for processing to the Custodian of Records office, 511 N. Sycamore, Santa Ana, Ca 92701. Phone (714) 834-3536; Fax (714) 835-9312.

Distribution: The bottom of the form indicates who will receive a copy of this request. The client/patient has a right to receive a copy of this form.

When requesting records from the Health Care Agency, please allow 5-10 working days to process the request and to receive the records.

If you have any questions, please call the Health Care Agency Custodian of Records Office at (714) 834-3536